COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Quality Improvement and Patient Protection Committee

September 22, 2015

Agenda

- Approval of Minutes from the July 8, 2015 Meeting
- Appointment of Committee Chair
- Discussion of Quality Measures Bulletin for Nurse Staffing Ratios in ICUs
- Discussion of Final Updates to Office of Patient Protection Regulations
- Discussion of 2014 Office of Patient Protection External Review Data
- Schedule of Next Meeting (November 12, 2015)

Agenda

- **Approval of Minutes from the July 8, 2015 Meeting**
- Appointment of Committee Chair
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Vote: Approving Minutes

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the minutes of the Committee meeting held on July 8, 2015, as presented.

Agenda

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- **Appointment of Committee Chair**
- Discussion of Quality Measures Bulletin for Nurse Staffing Ratios in ICUs
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Vote: Chair Appointment

Motion: That, pursuant to Article 4.1 of the Health Policy Commission By-Laws, the Quality Improvement and Patient Protection Committee members appoint Martin Cohen as Chairperson of the Committee.

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Update on Nurse Staffing Quality Measures

- Following approval by the Commission in June 2015, the HPC **promulgated 958 CMR 8.00** (effective 7/3/15)

- The HPC will identify the **3 to 5 related patient safety quality indicators** required to be measured and reported by hospitals to the public (M.G.L. c. 111, § 231) in sub-regulatory guidance in the form of a bulletin

- In June 2015, the Commission finalized the following four quality measures:
  - (1) Central Line-Associated Blood Stream Infection (CLABSI) – National Quality Forum (NQF) #0139
  - (2) Catheter-Associated Urinary Tract Infection (CAUTI) – NQF #0138
  - **(3) Pressure Ulcer Prevalence (hospital acquired) – NQF #0201**; and
  - (4) Patient Falls with Injury – NQF #0202

- On July 8, 2015, HPC staff advised the QIPP Committee that due to a decision by the measure steward (the Joint Commission) to relinquish its stewardship for resource reasons, **NQF #0201** is not currently endorsed by NQF

- Based on subsequent research, there is **no indication of a material change in the value of the measure** for the purposes of collection and reporting in connection with the ICU nurse staffing law and regulation
  - HPC staff understand that despite a lack of endorsement, hospitals will continue to collect and report the measure
  - The measure description remains on NQF's website
  - Another entity could become steward of the measure

- Based on the facts known at this time, HPC staff recommend (1) **retaining NQF #0201** as a required measure and (2) **proceeding with development and issuance of the bulletin**

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Office of Patient Protection Regulation Updates

Medical Necessity Criteria

958 CMR 3.101

- Changes to state law providing access to medical necessity criteria took effect on July 1, 2014, pursuant to FY 2015 budget*
- Updates are required to conform regulation to applicable Massachusetts law
- Updates will clarify expanded access to proprietary and non-proprietary medical necessity criteria

Open Enrollment Waivers

958 CMR 4.000

- Updates are required to conform regulation to Affordable Care Act and related Massachusetts law
- Definition of “eligible individual” changed
- Updates would not significantly change waiver process

* Ch. 165 of the Acts of 2014, sections 18, 172 & 173 amending M.G.L. c. 6D, §16(a); c. 176O, §§12(a) & 16(b)

Five public comments received

Advocacy organizations

- Health Care For All*
- Health Law Advocates*

Payer organizations

- Massachusetts Association of Health Plans

Provider organizations

- Association for Behavioral Healthcare*
- Clinicians United
- Massachusetts Hospital Association
- Massachusetts League of Community Health Centers*
- Massachusetts Medical Society*
- Massachusetts Psychological Association
- Massachusetts Psychiatric Society*
- National Association of Social Workers*

* Submitted one comment with multiple signatories

Medical Necessity Criteria Regulation, 958 CMR 3.101

OPP Regulation	Proposed Update
958 CMR 3.101(3)(b)	Replace current language. Criteria will be disclosed to OPP, proprietary criteria not subject to Mass. public records laws, M.G.L. c. 4, §7, clause Twenty-sixth and M.G.L. c. 66, §10.
958 CMR 3.101(3)(c)	Non-proprietary criteria: access to the general public.
958 CMR 3.101(3)(d)	Proprietary criteria: access to insureds, prospective insureds and health care providers. Requester must identify particular treatments or services for which applicable criteria or protocols are requested.
958 CMR 3.101(3)(e)	**Added clarifying language to highlight existing right to obtain criteria through health insurance appeals process**
958 CMR 3.101(4)	Non-proprietary criteria: publication on publicly available website, must be up to date.
958 CMR 3.101(5)	Insurance carrier must provide requested criteria as soon as possible and within **21 days** (instead of 30 days).

Additional proposed changes highlighted in bold.

Open Enrollment Waiver Regulations, 958 CMR 4.000

OPP Regulation	Proposed Update
958 CMR 4.020	Change definition of “creditable coverage” to add ACA-compliant plans, remove YAP plans which are no longer offered
958 CMR 4.020	Change definition of “eligible individual” to comply with changes to statute; resident of Massachusetts
958 CMR 4.020	Minor clarifications to definitions of “health plan,” “intentionally forgo enrollment” and “nongroup health plan”
958 CMR 4.030	Add reference to ACA, remove outdated waiver eligibility requirements
958 CMR 4.050	Updates to include reference to ACA; include reference to Health Connector as additional source of guidance
958 CMR 4.060	Minor clarification to wording
958 CMR 4.070	Change reporting date from July 1 to April 1 to consolidate and simplify report to OPP

No further changes suggested.

Proposed timeframe to update OPP regulations

Sept. 22, 2015
Review of final regulations by QIPP Committee

October 21, 2015
Review of final regulations by Commission

November 6, 2015
If approved, effective date of updated regulations

Vote: Approving and advancing proposed regulations

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the advancement of the FINAL updates to Office of Patient Protection regulations, 958 CMR 3.00, Health Insurance Consumer Protection, and 958 CMR 4.00, Health Insurance Open Enrollment Waivers, and recommends that the Commission vote to approve the FINAL updates to the regulations for public comment at its meeting on October 21, 2015.

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Office of Patient Protection Overview

History of the Office of Patient Protection

- Created in 2000 to protect Massachusetts managed care consumers (Ch. 141)
- OPP operated within the Department of Public Health (DPH)
  - Consumer rights to challenge health plan coverage denials
  - Massachusetts fully-insured plans only
- Chapter 224 moved OPP from DPH to HPC
- OPP transfer took effect April 20, 2013

Main responsibilities

- Regulating internal and external review for fully-insured plans
- Administering external review for fully-insured plans
- Consumer assistance and education
- Administering enrollment waivers to purchase non-group health insurance
- Receiving and analyzing annual reports from health plans about appeals, disenrollment of providers, other mandated information
- Developing and regulating an appeals process for patients in risk bearing provider organizations (RBPOs)

Internal review process

Process for consumer with a fully-insured Mass. health plan

1. Consumer receives denial letter from carrier

- Denial of prior authorization or denial of claim, must be in writing
- May be based on medical necessity or other reasons
- Consumer may request expedited internal review
- Consumer may request continuation of coverage

2. Consumer appeals directly to carrier

- May appeal in writing or over the phone (carrier puts in writing)
- Carrier responds within 30 days unless voluntary extension
- Carrier responds within two days if expedited

3. Carrier responds to consumer

- Written response to consumer
- Carrier may reverse, modify or uphold original decision

4. Further appeal rights

- Voluntary reconsideration if offered by carrier
- If denial based on **medical necessity**, may seek external review through OPP

External review process

Process for consumer with a fully-insured Mass. health plan, after pursuing internal review

1. Consumer receives 2nd denial from carrier

- Consumer receives written denial notice/final adverse determination from carrier
- External review if **medical necessity**
- Consumer may request expedited external review
- Consumer may request continuation of coverage

2. Consumer requests external review

- Deadline: 4 months from the date the insured receives the final adverse determination
- Submit completed external review form, copy of final adverse or adverse determination & $25 fee if applicable, any supporting documents

3. Independent external review

- OPP reviews for eligibility
- If eligible, OPP sends to external review agency (ERA)
- ERA requests file from carrier
- ERA applies Mass. medical necessity standard
- Standard: 45 days
- Expedited: 72 hours

4. Next steps

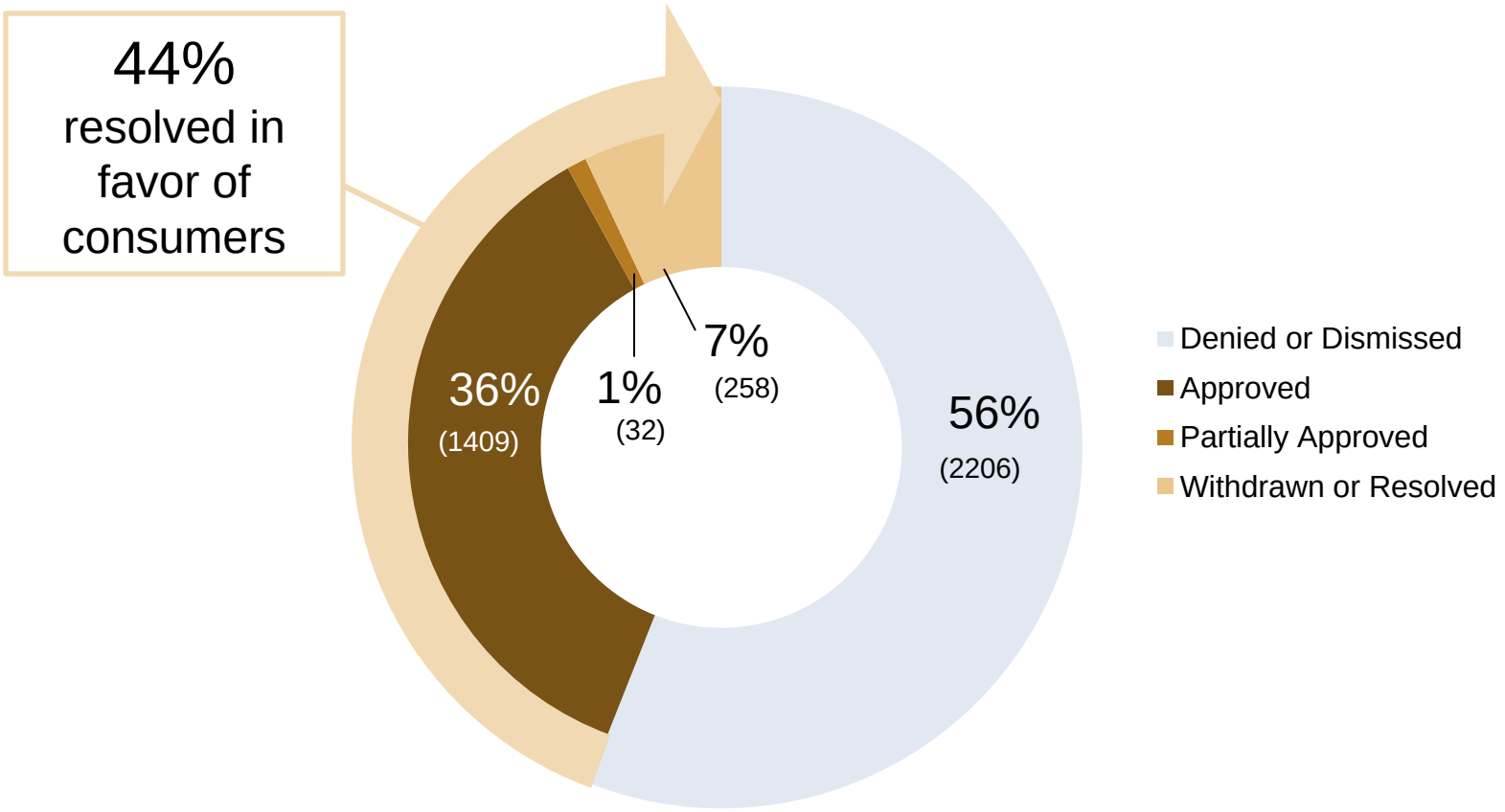
- ERA may uphold, overturn, or partially overturn
- ERA sends written decision to insured, representative, OPP, carrier
- Carrier must respond within 5 days, implement without delay
- Final and binding decision

During 2014, insurance companies received 11,366 complaints from members. Of these, 3,906 were member grievances based on adverse determinations, and insurers resolved 44% fully or partially in favor of the member.

Internal Review

Adverse Determinations

Insurance companies reported 3,906 member grievances in 2014, which were internally reviewed by the insurance companies.



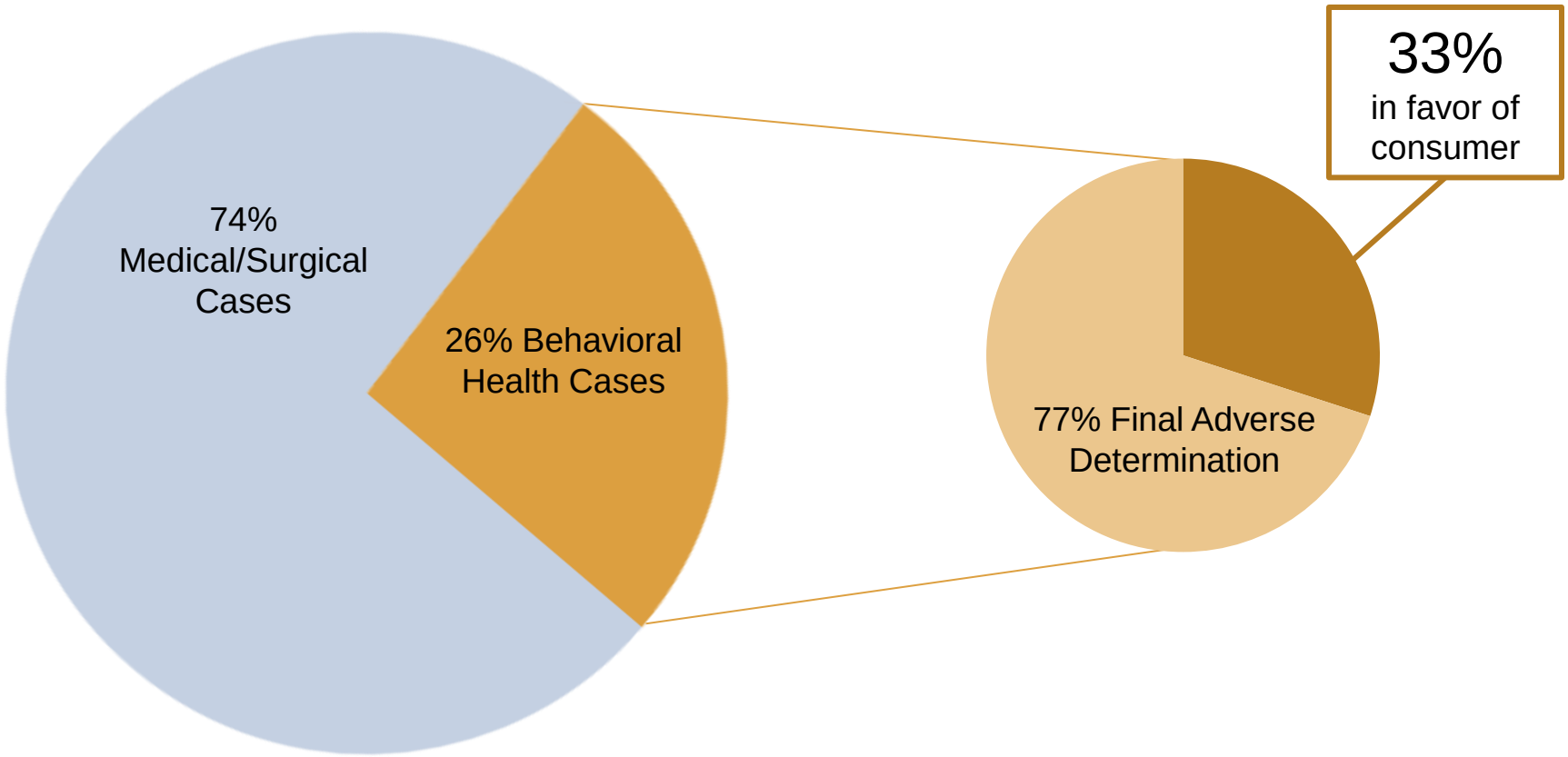
Source: 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

Insurers reported that about 26% of requests for internal review (grievances) involved behavioral health services. Insurers resolved about 33% in favor of the member

Internal Review

Adverse Determinations

Behavioral Health

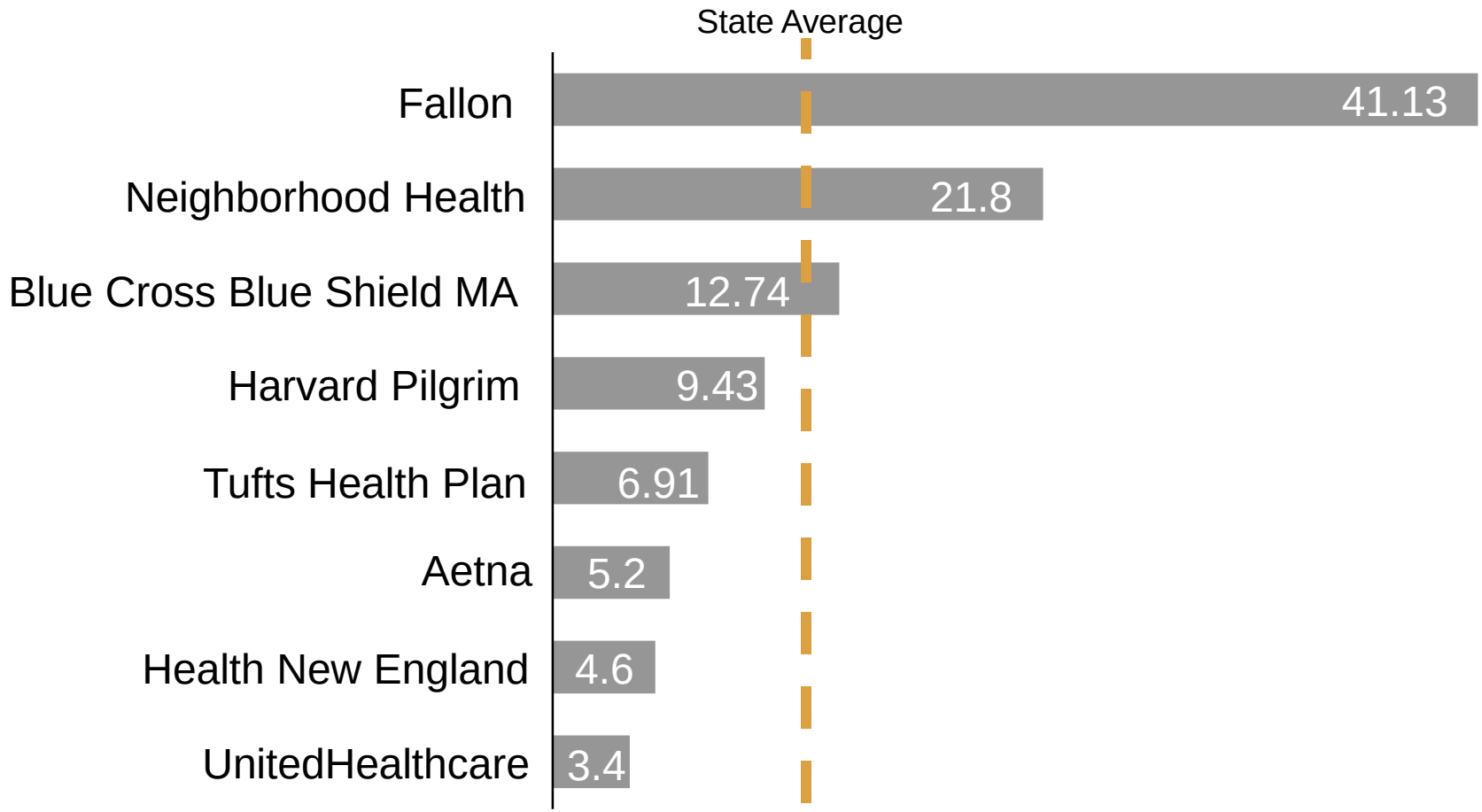


When weighted for the number of members in each plan, Fallon reported the highest proportions of internal reviews (grievances resulting from adverse determinations) during 2014, for insurers with more than 10,000 fully insured members.

Internal Review

Adverse Determinations

Number of internal reviews per 100,000 members reported by insurance company, weighted by reported member months by insurance company



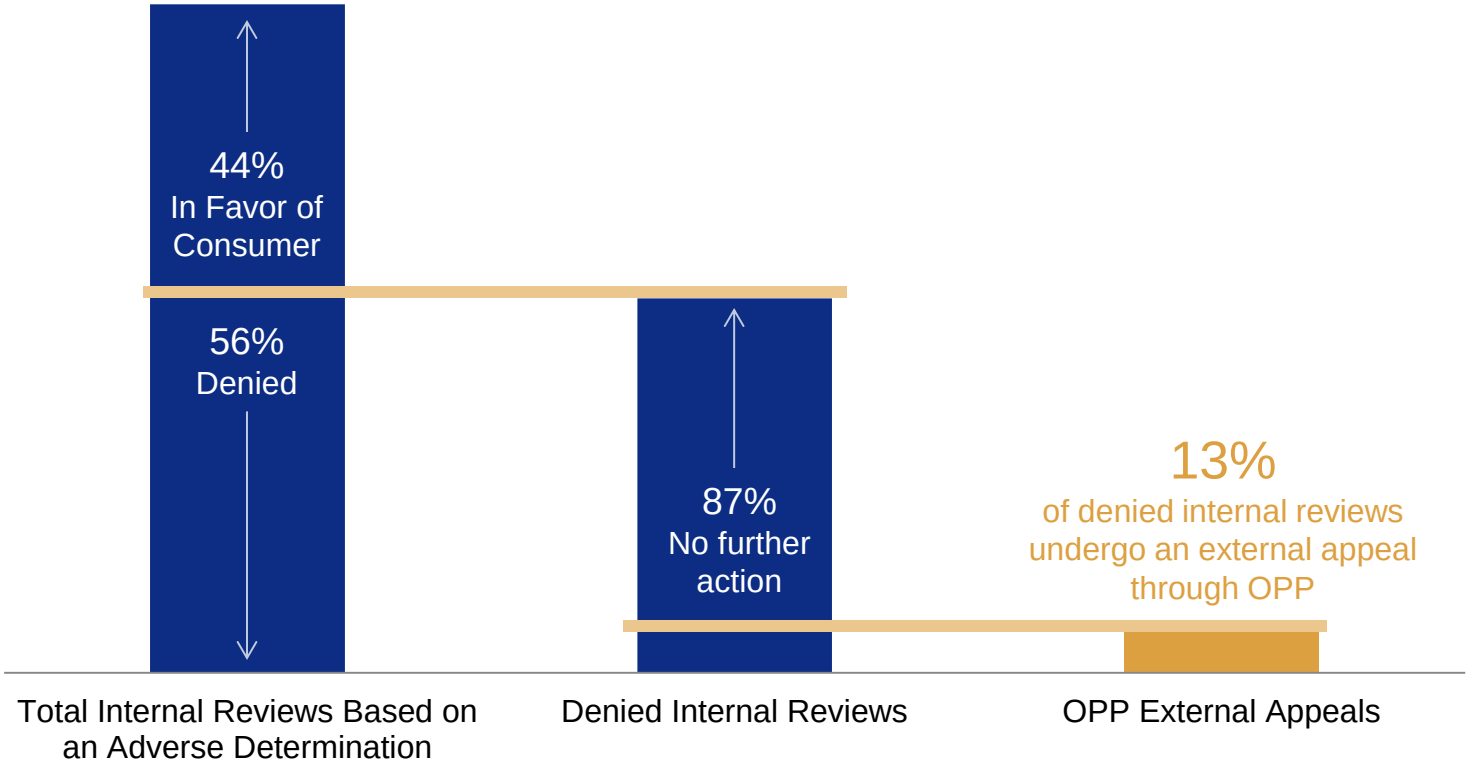
Source: 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600.
Weighted by dividing number of internal reviews by most recent health plan reported member month data. Center for Health Information and Analysis, 2013

Of those receiving adverse determinations during 2014, 13% of members with internal reviews that were denied or partially denied then pursued external appeals through OPP.

External Review

Adverse Determinations

The proportion of members who were denied or partially denied during the internal review process and who filed eligible external review requests with OPP

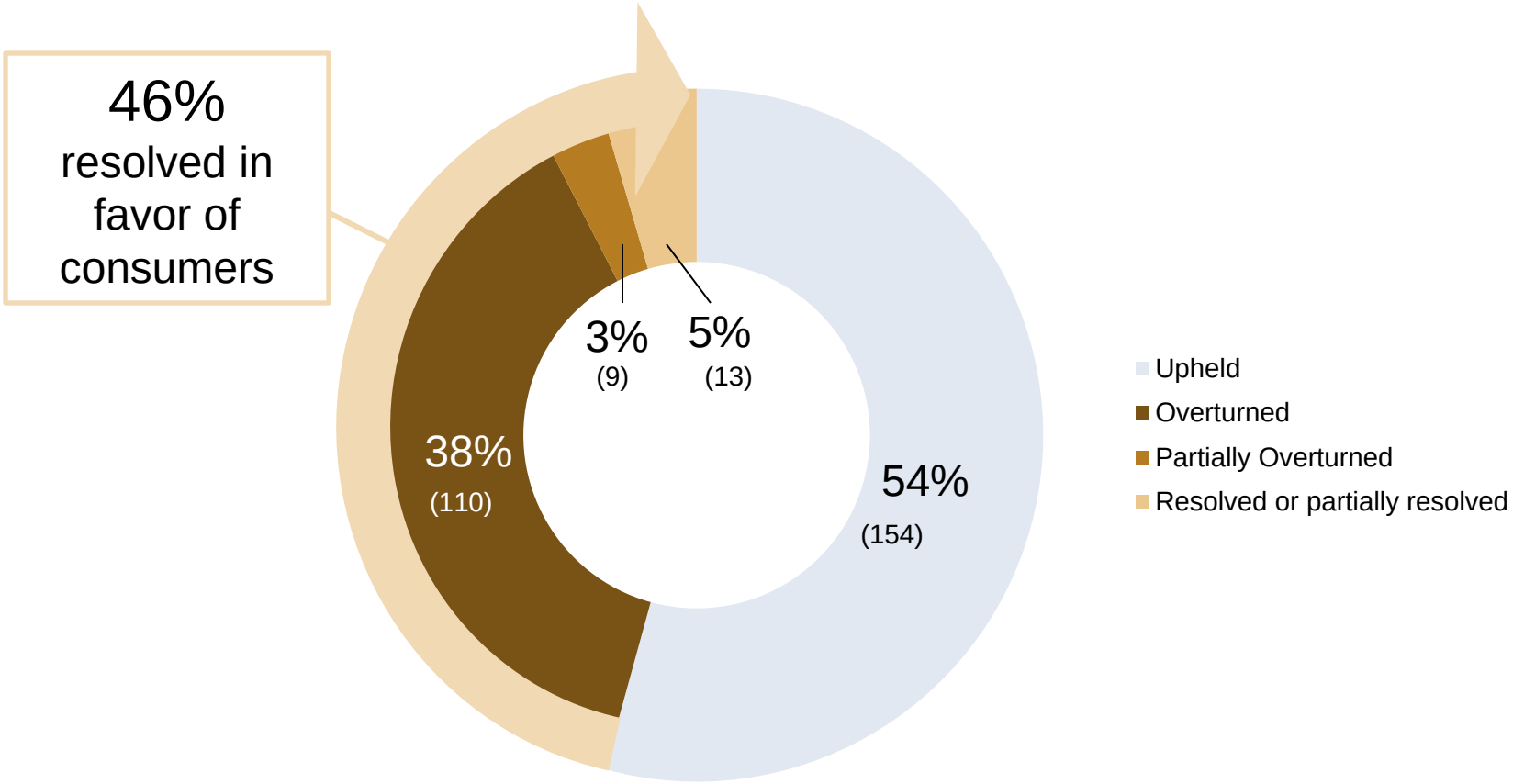


Source: 2014 Office of Patient Protection external review data; 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

OPP received 286 eligible requests for external review during 2014. Similar to past years, nearly half were decided in favor of the patient.

External Review

Percentage of external review cases by outcome, 2014

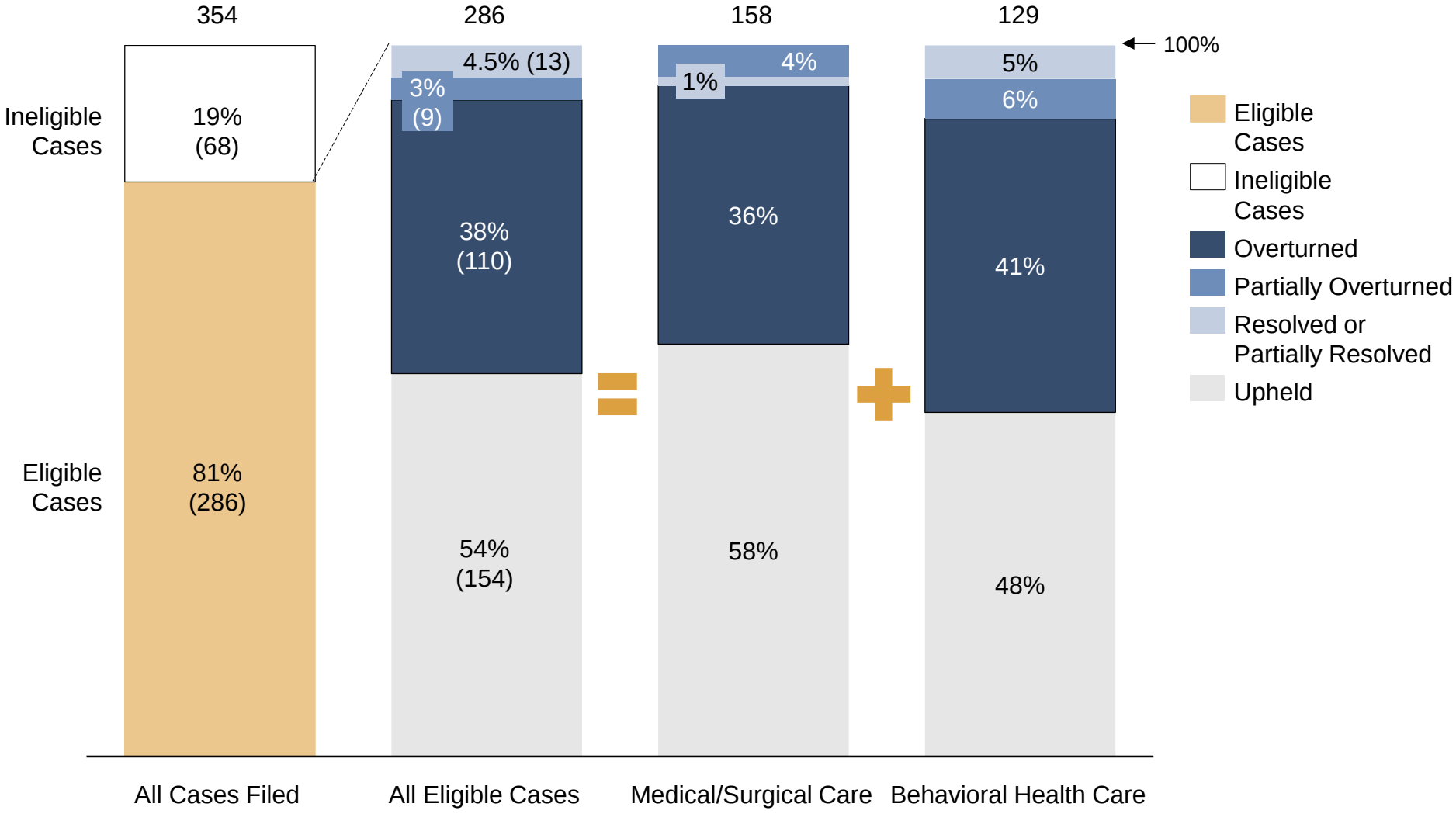


Source: 2014 Office of Patient Protection external review data

During 2014, OPP received 354 external review requests. Of the 286 eligible cases, OPP received 158 requests for medical/surgical treatment and 129 requests for behavioral health treatment.

External Review

Percentage of external review cases by disposition, by type of case (Medical/Surgical Care vs. Behavioral Health Care), 2014



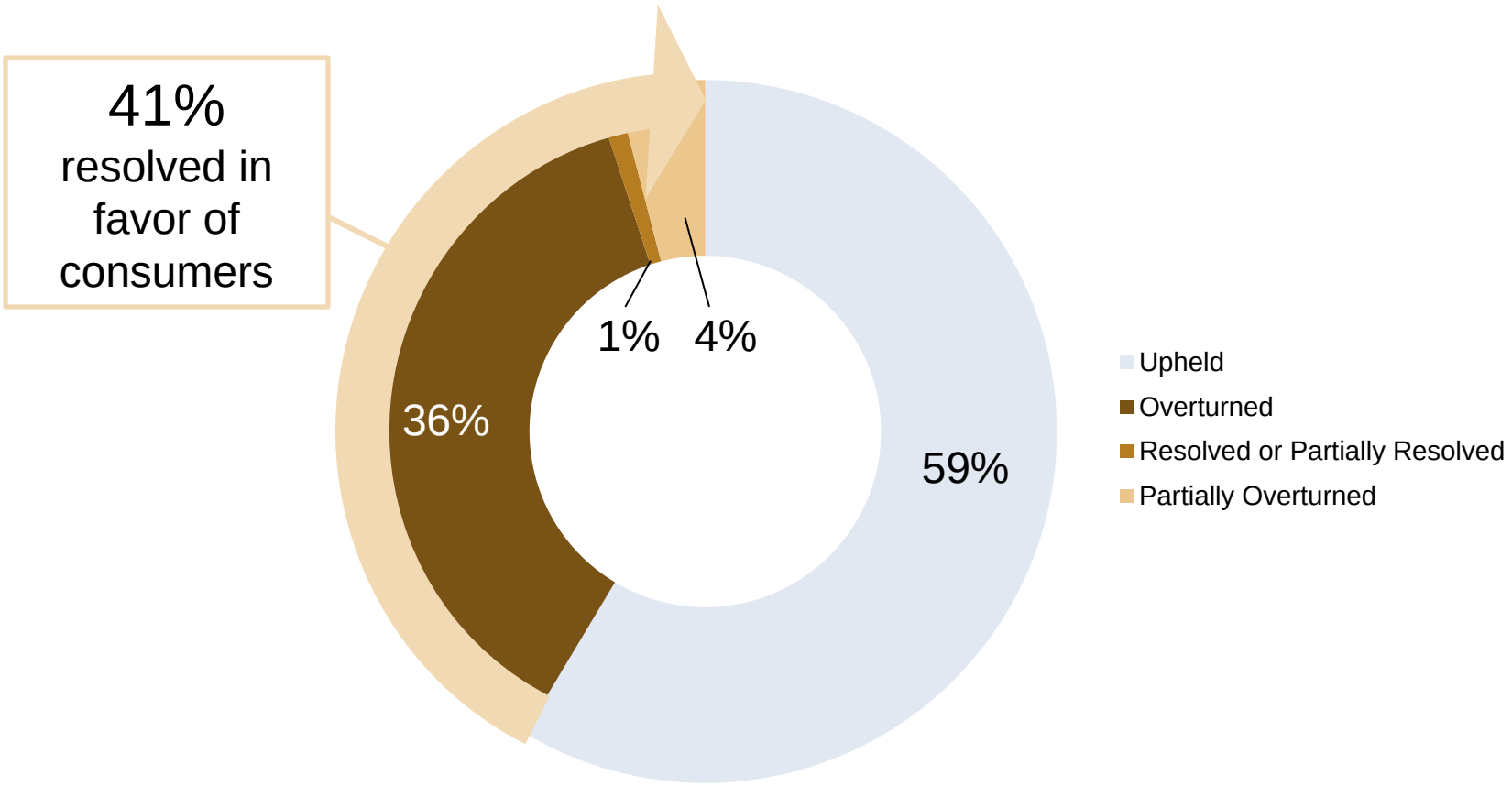
Source: 2014 Office of Patient Protection external review data

41% of the medical/surgical treatment requests were resolved fully or partially in favor of the patient.

External Review

Medical/Surgical

Outcomes of eligible external reviews for medical/surgical service requests in 2014



Outcomes of eligible external reviews for medical/surgical service requests in 2014.

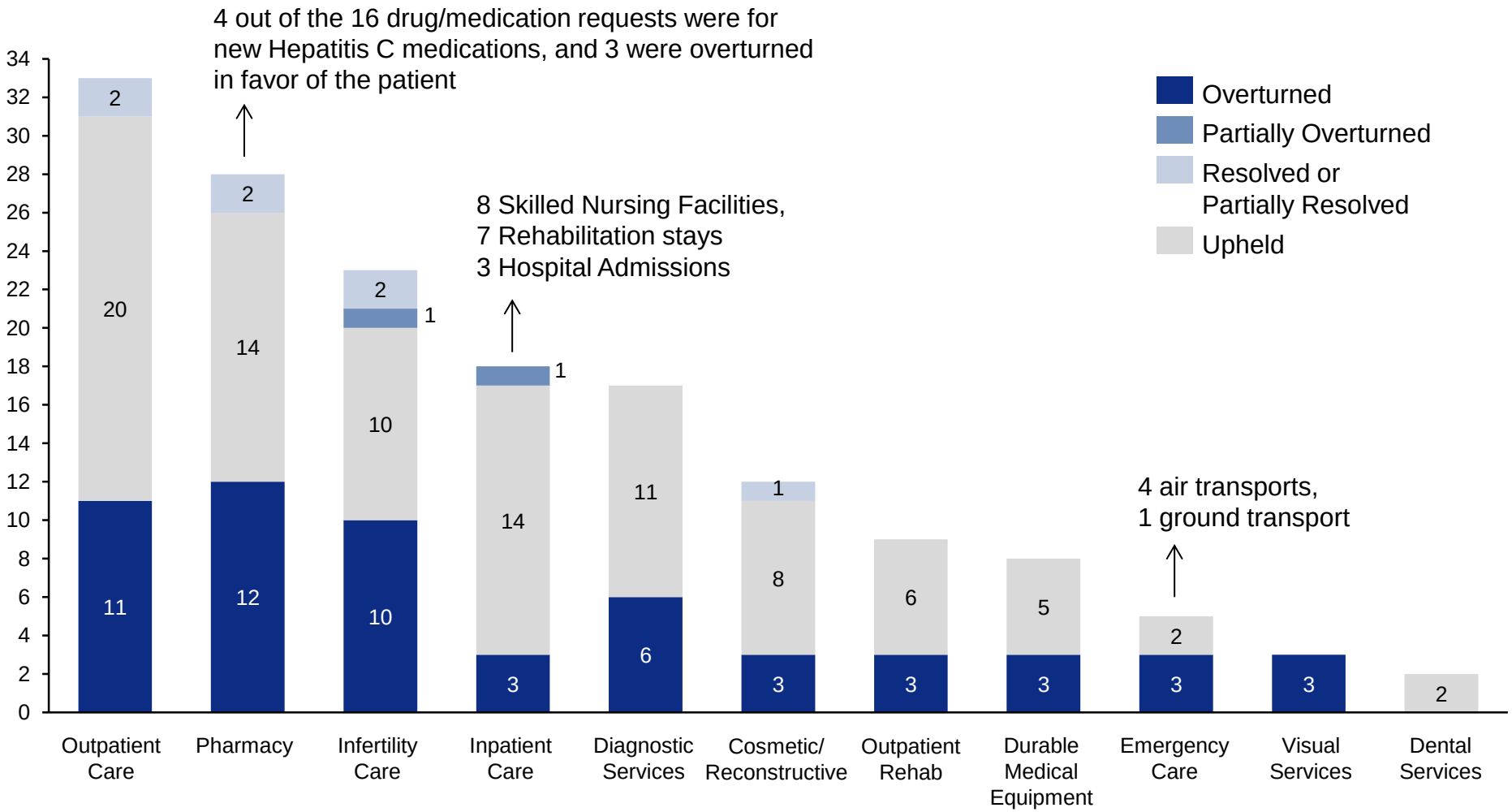
Source: 2014 Office of Patient Protection external review data

In 2014, patients filed requests for external review for the following types of medical or surgical treatment.

External Review

Medical/Surgical

Proportion of eligible external reviews in Medical/Surgical Care by category of treatment (2014)



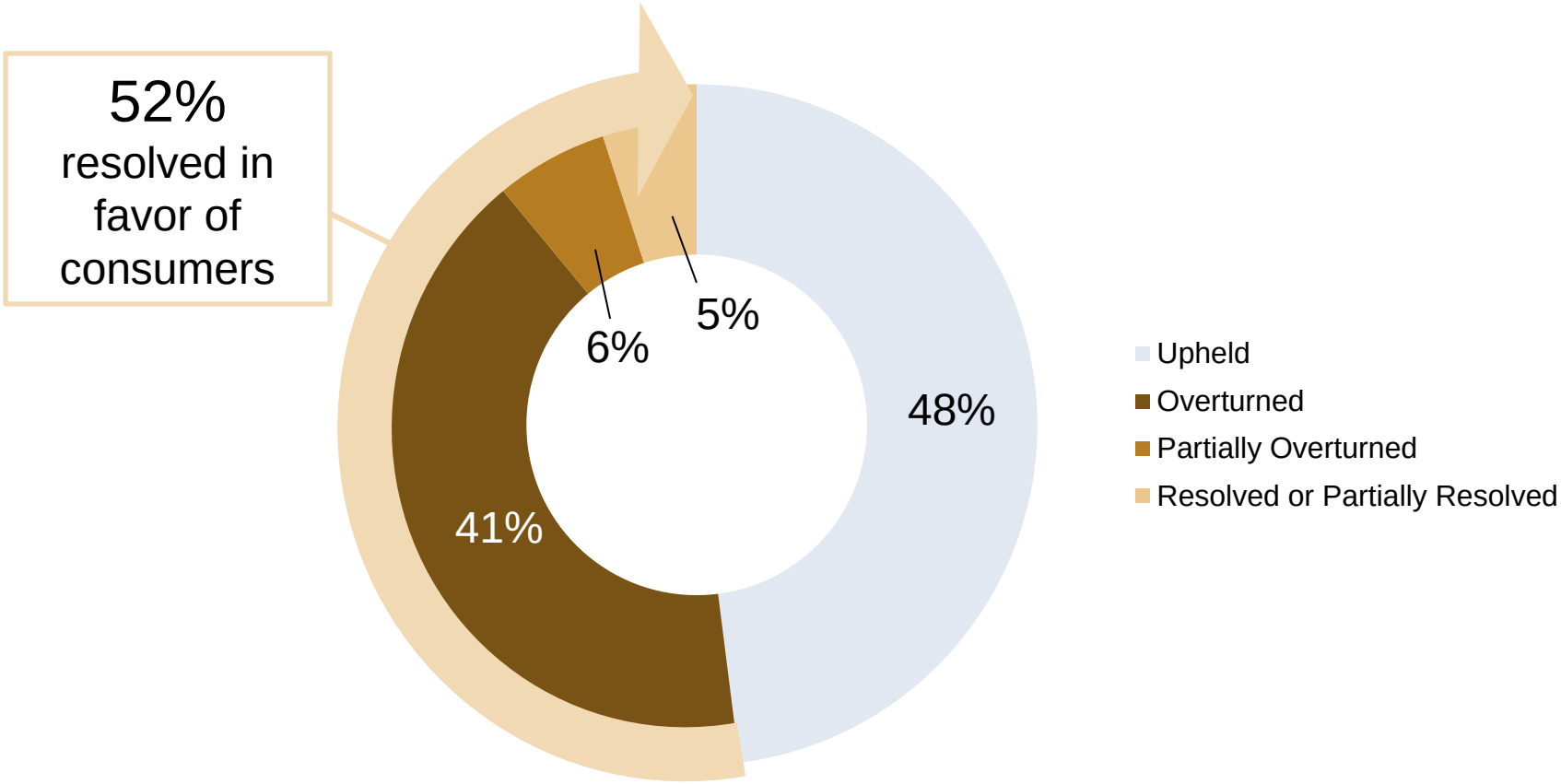
Source: 2014 Office of Patient Protection external review data

52% of eligible external review cases for behavioral health treatment were decided fully or partly in favor of the patient, a slight increase from 2013.

External Review

Behavioral Health

Eligible external reviews related to behavioral health treatment by outcome, 2014



Eligible external reviews related to behavioral health treatment by outcome, 2014

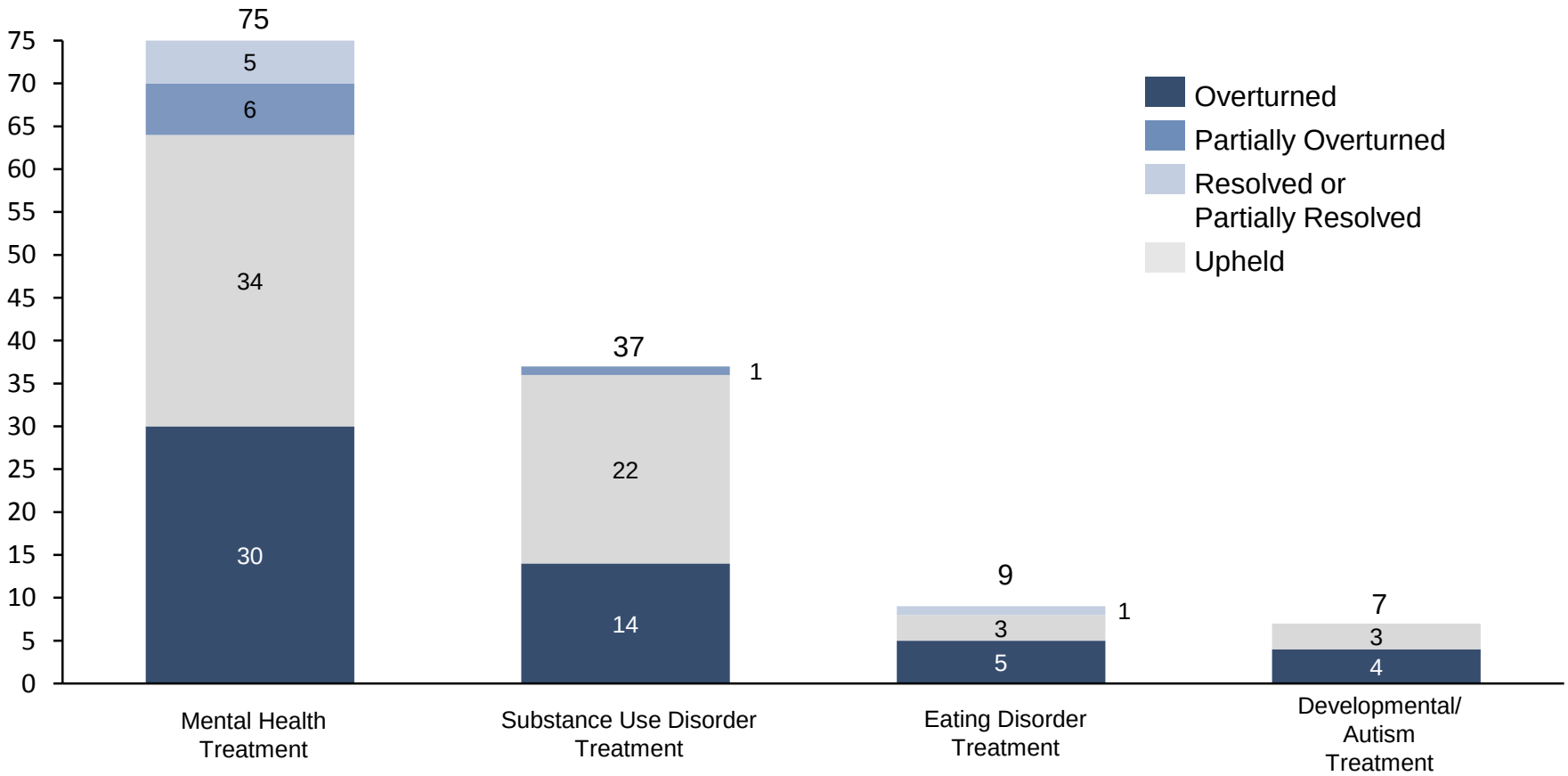
Source: 2014 Office of Patient Protection external review data

OPP categorizes mental health, substance use disorder, eating disorder, and development/autism treatment as behavioral health services.

External Review

Behavioral Health

Eligible external reviews related to behavioral health treatment by outcome and type of case, 2014

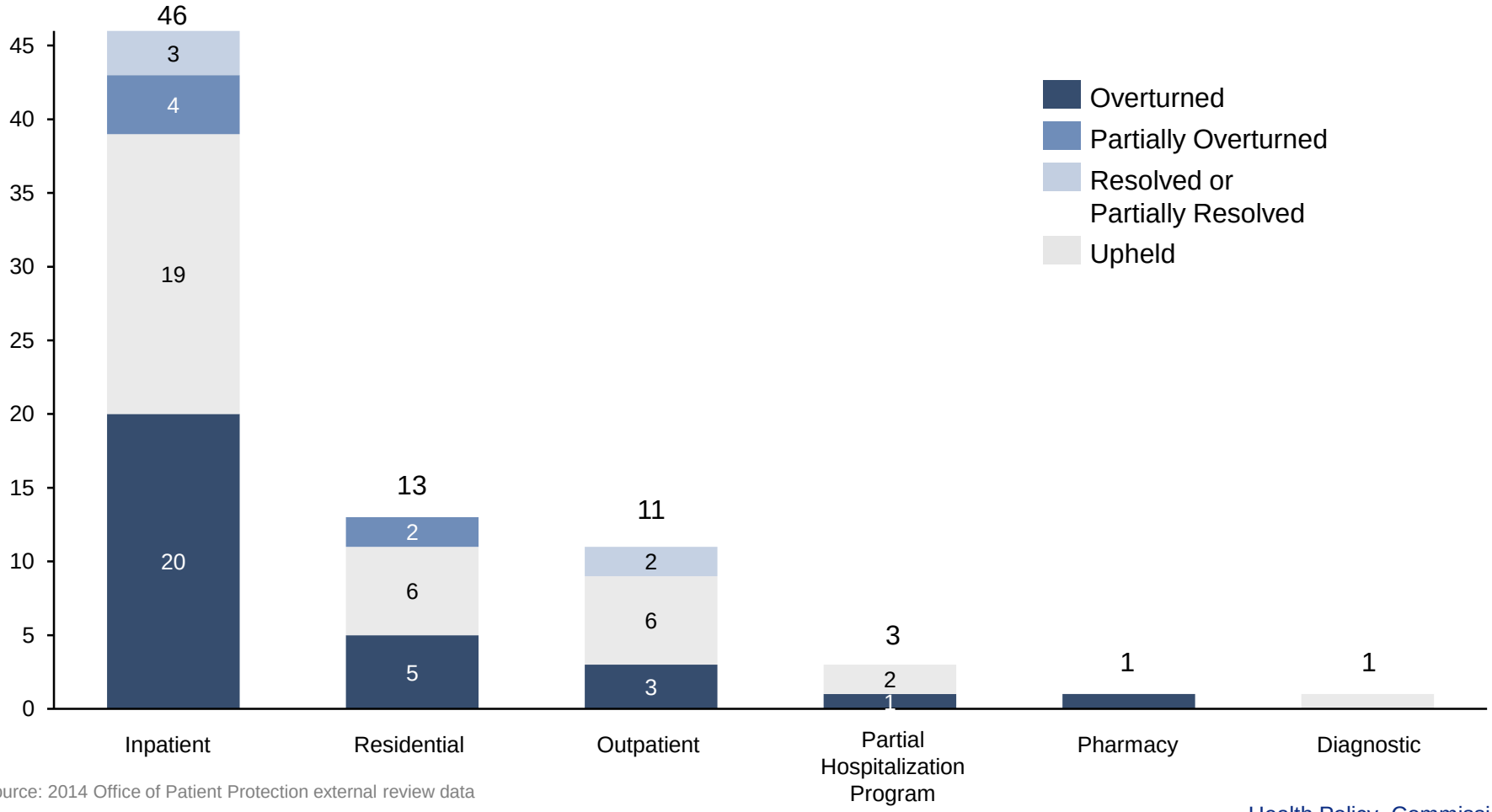


Source: 2014 Office of Patient Protection external review data

Within the category of behavioral health external review requests, OPP handled the following types of requests for mental health treatments.

External Review
Behavioral Health
Mental Health

Eligible external reviews related to mental health treatment by outcome and type of service requested, 2014

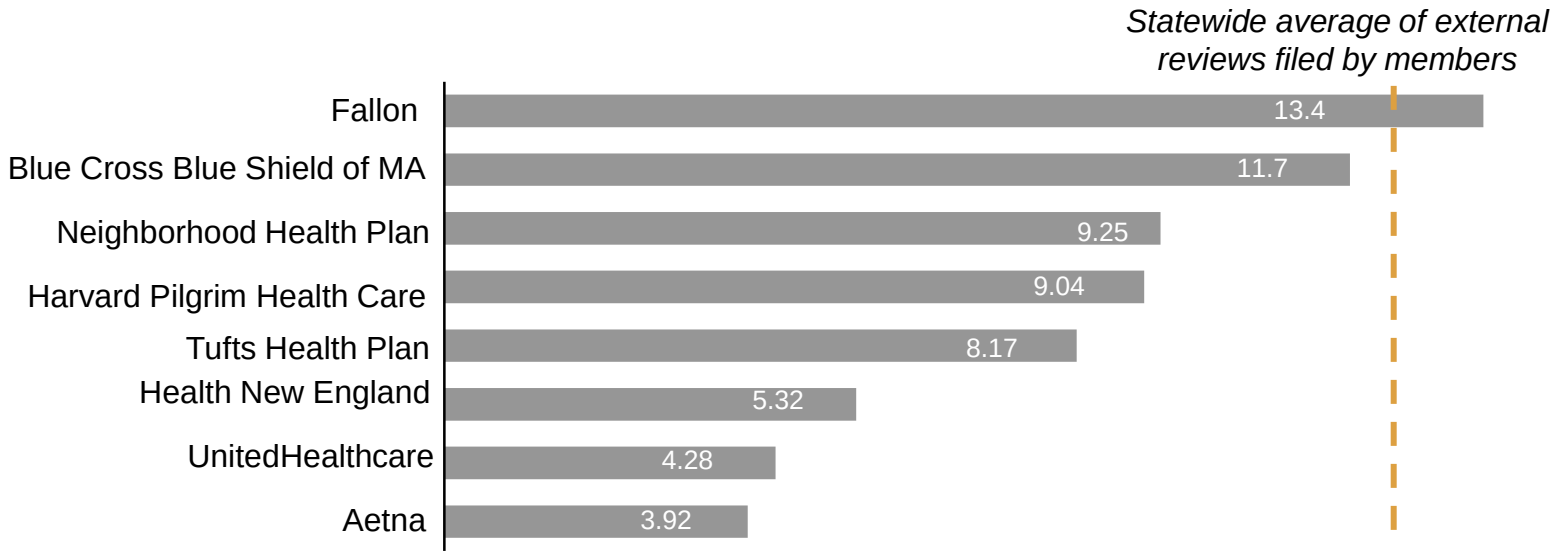


Source: 2014 Office of Patient Protection external review data

When weighted by number of members, Fallon members sought a higher than average number of external reviews

External Review

Number of external reviews (2014) per 1,000,000 members weighted by number of enrolled member months



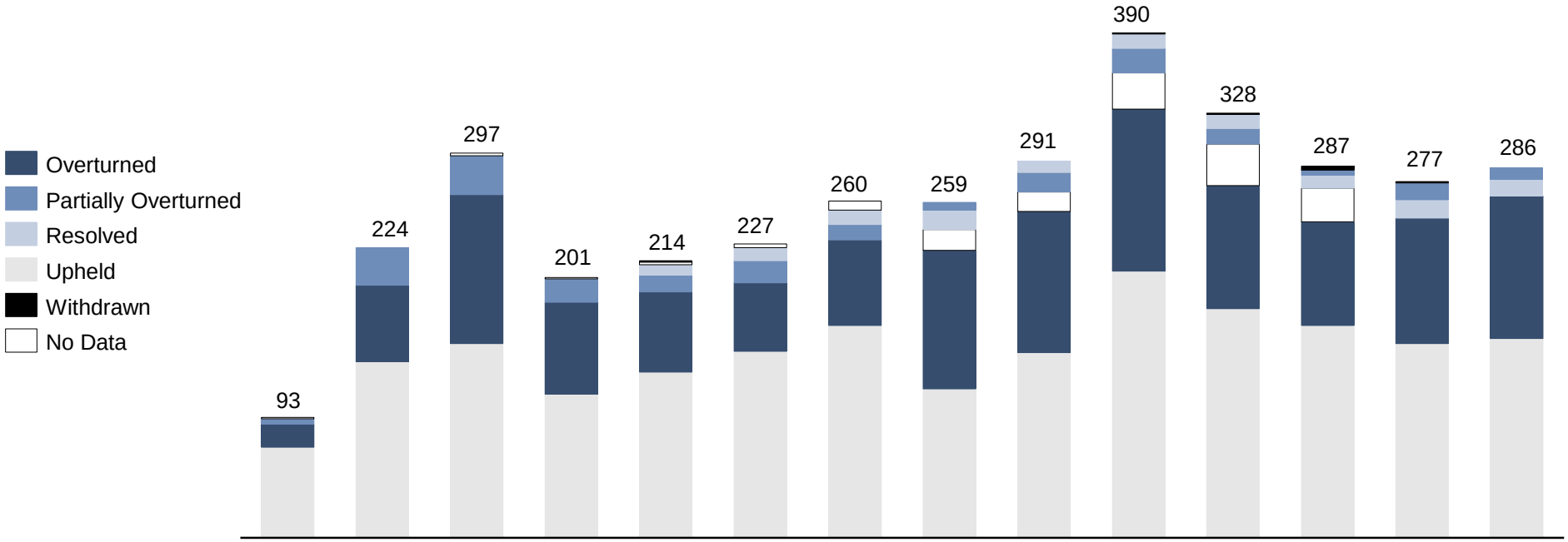
Note: Weighted by dividing number of external reviews by most recent health plan reported member month data. Center for Health Information and Analysis, 2013

Source: 2014 Office of Patient Protection external review data, Member months from Center for Health Information and Analysis, 2012

The number of external review cases has varied, but the proportion of cases resolved in favor of the patient has remained relatively constant.

External Review

Number of eligible external review cases over time, by disposition, 2001 to 2014



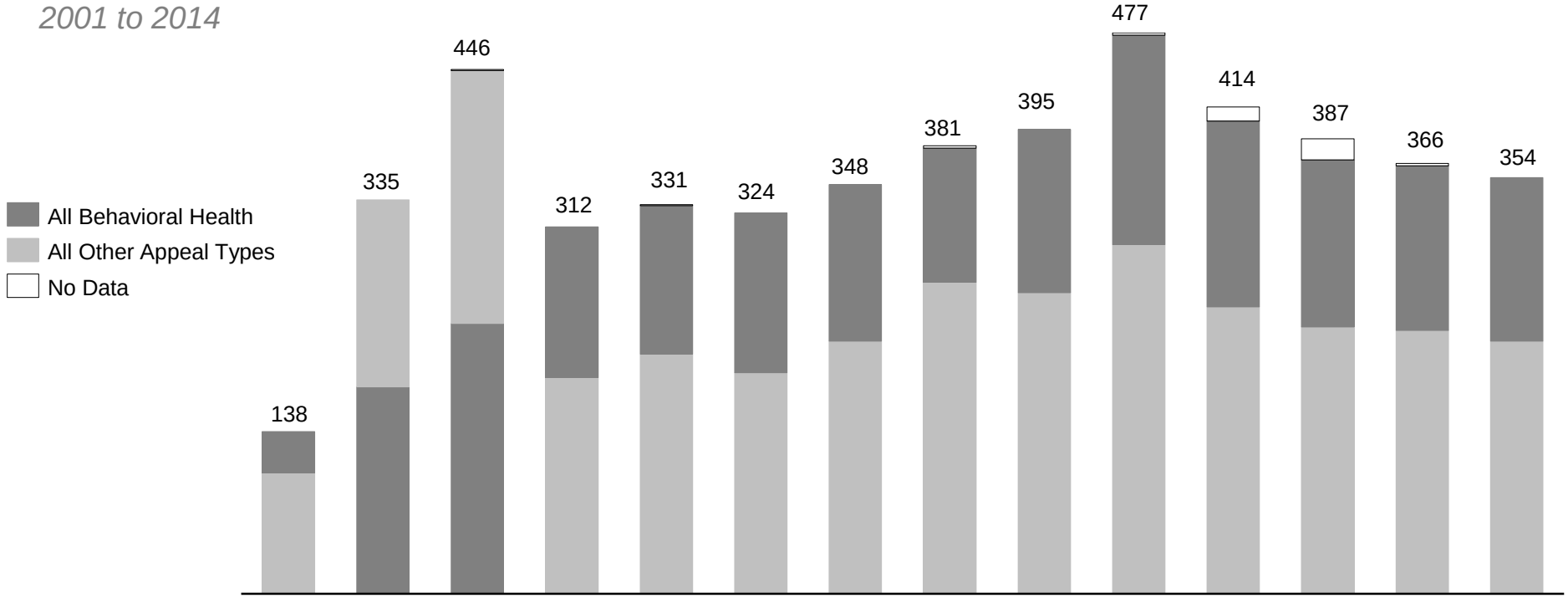
Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Overturned	18	59	115	71	62	53	66	107	109	125	95	80	97	110
Partially Overturned	4	29	30	18	13	17	12	6	15	19	12	4	15	9
Resolved	0	0	0	0	8	10	11	15	9	11	11	10	14	13
Upheld	70	136	150	111	128	144	164	115	143	206	177	164	150	154
Withdrawn	0	0	0	0	1	0	0	0	0	1	1	3	1	0
No Data	1	0	2	1	2	3	7	16	15	28	32	26	0	0
Total	**93**	**224**	**297**	**201**	**214**	**227**	**260**	**259**	**291**	**390**	**328**	**287**	**277**	**286**

Source: 2001-2014 Office of Patient Protection external review data

Comparison of the number of medical/surgical external review requests to the behavioral health external review requests from 2001 to 2014

External Review

Number of all external review requests (ineligible and eligible) over time, by type of service 2001 to 2014



Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
All Behavioral Health	35	176	230	128	126	136	133	114	139	178	158	142	140	139
All Other Appeal Types (medical/surgical)	103	159	215	184	204	188	215	265	256	297	244	227	224	215
No Data	0	0	1	0	1	0	0	2	0	2	12	18	2	0
Total	**138**	**335**	**446**	**312**	**331**	**324**	**348**	**381**	**395**	**477**	**414**	**387**	**366**	**354**

Source: 2001-2014 Office of Patient Protection external review data

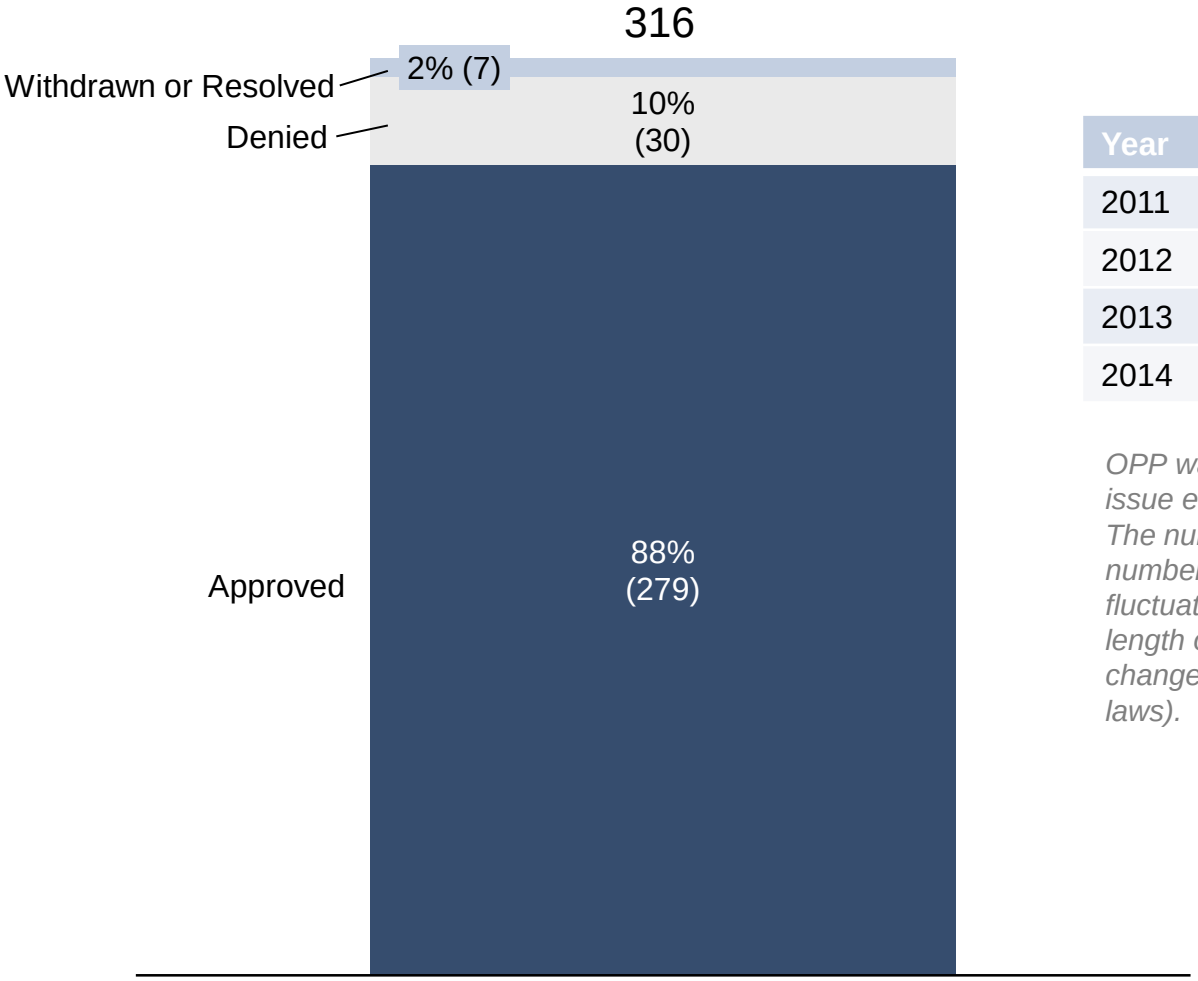
Waivers to buy non-group health insurance outside of open enrollment

OPP responsibility pursuant to M.G.L. c. 176J, §4(4)

- 2015 open enrollment through the Health Connector ended Feb. 23, 2015, 2016 open enrollment begins on November 1, 2015
- When enrollment is closed, you can usually buy insurance if you have a qualifying event or special enrollment period, e.g.,
  - Eligible for subsidized insurance (income below 300% FPL)
  - You lost insurance coverage recently (usually within the past 60 or 63 days)
  - You are a small business owner buying insurance for your business
- May be eligible for an enrollment waiver if Massachusetts resident and, e.g.,
  - You are uninsured and did not intentionally forgo enrollment in health insurance
  - You lost insurance coverage but did not find out until after 60 days had passed

Outcomes of 2014 open enrollment waiver applications

During 2014, most applicants had a valid reason for missing their enrollment window. Others were given waivers to expedite the process of obtaining health insurance even when their situation did not require an OPP waiver, to help consumers who attempted to enroll through the Health Connector.



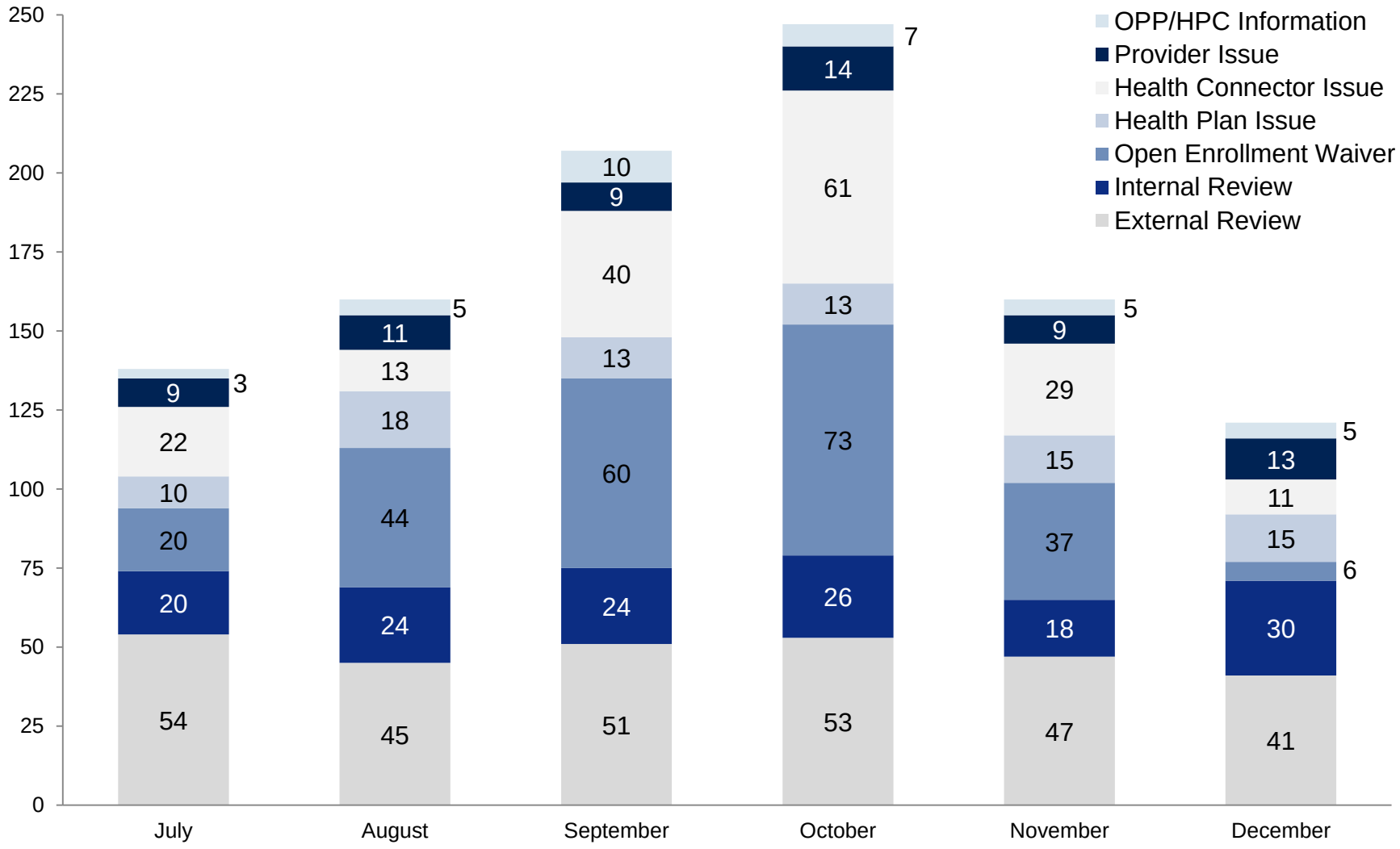
Year	Total Waiver Applications
2011	276
2012	576
2013	416
2014	316

OPP was given the statutory authority to issue enrollment waivers beginning in 2011. The numbers of applications and the numbers of waivers approved have fluctuated for a variety of reasons (e.g. length of open enrollment periods, changes to state and federal enrollment laws).

Source: 2011-2014 Office of Patient Protection Waiver Data

OPP Hotline: During 2014, OPP answered an average of 172 calls and emails per month, with an increase in calls in September and October for open enrollment waivers.

July 2014 through December 2014 phone calls and emails to OPP by topic



Source: 2014 Office of Patient Protection Call Logs

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Contact Information

For more information about the Health Policy Commission:

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